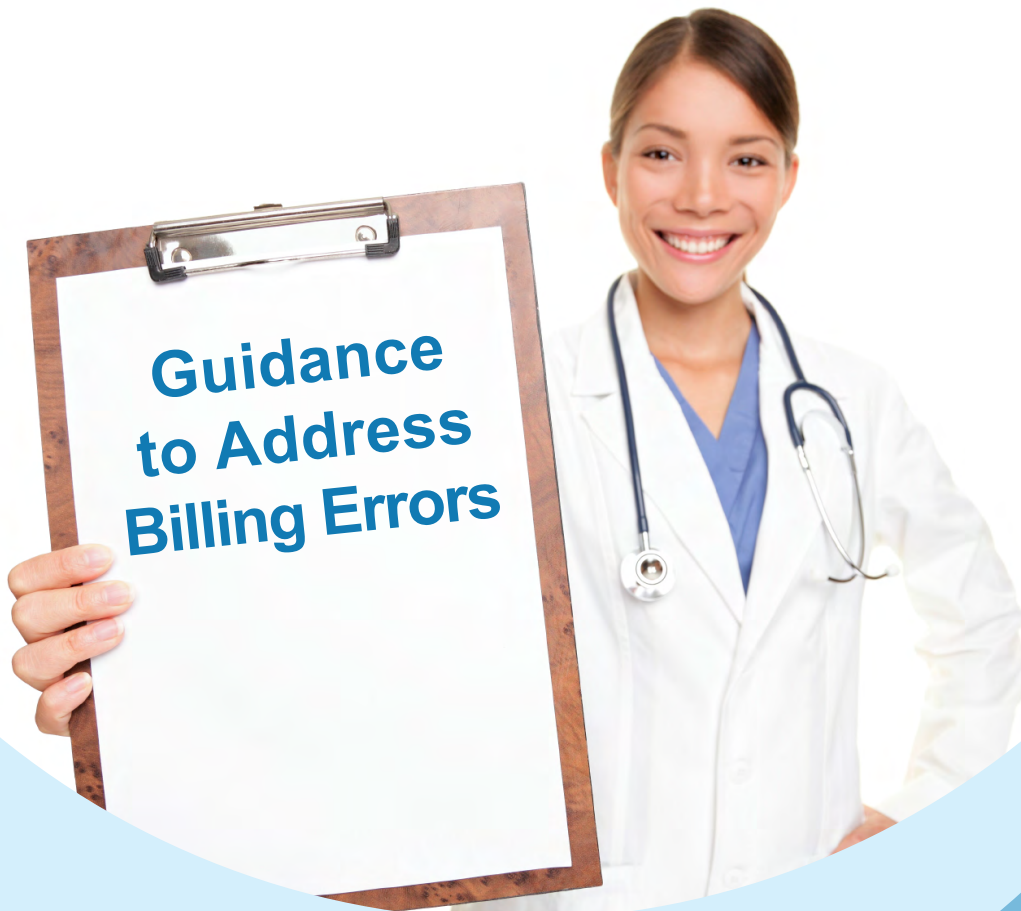


DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Official CMS Information for
Medicare Fee-For-Service Providers

Medicare Quarterly Provider Compliance Newsletter



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Introduction

The Medicare Fee-For-Service (FFS) program contains a number of payment systems, with a network of contractors that process more than 1 billion claims each year, submitted by more than 1 million providers, including hospitals, physicians, Skilled Nursing Facilities, clinical laboratories, ambulance companies, and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). These contractors, called “Medicare claims processing contractors,” process claims, make payments to health care providers in accordance with Medicare regulations, and educate providers regarding how to submit accurately coded claims that meet Medicare guidelines. Despite actions to prevent improper payments, such as pre-payment system edits and limited medical record reviews by the claims processing contractors, it is impossible to prevent all improper payments due to the large volume of claims. In the Tax Relief and Health Care Act of 2006, the U.S. Congress authorized the expansion of the Recovery Audit Program nationwide by January 2010 to further assist the Centers for Medicare & Medicaid Services (CMS) in identifying improper payments. Medicare FFS Recovery Auditors are contractors that assist CMS by performing claim audits on a post-payment basis.

Recovery Auditors are required to use clinicians, such as registered nurses or therapists for coverage/medical necessity determinations, and certified coders for coding determinations. Auditors are not authorized to go outside of their scope of practice. Some reviews may require the skills of both a clinician and a coder.

CMS issues the “Medicare Quarterly Provider Compliance Newsletter,” a Medicare Learning Network® (MLN) educational product, to help providers understand the major findings identified by Medicare Administrative Contractors (MACs), Recovery Auditors, Program Safeguard Contractors, Zone Program Integrity Contractors, and other governmental organizations, such as the Office of Inspector General. This is the January 2012 issue of the newsletter and is designed to help FFS providers, suppliers, and their billing staffs understand their claims submission problems and how to avoid certain billing errors and other improper activities, such as failure to submit timely medical record documentation, when dealing with the Medicare FFS program. An archive of previously issued newsletters is also available to providers in case they missed one. This archive can be found at http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf on the CMS website.

The newsletter describes the problem, the issues that may occur as a result, the steps CMS has taken to make providers aware of the problem, and guidance on what providers need to do to avoid the issue. In addition, the newsletter refers providers to other documents for more detailed information wherever they may exist.

The findings addressed in this newsletter are listed in the Table of Contents and can be navigated to directly by “left-clicking” on the particular issue in the Table of Contents. A searchable index of keywords and phrases contained in both current and previous newsletters can be found at http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Index.pdf on the CMS website.

Recovery Audit Finding: Ambulance Services Separately Payable During an Inpatient Hospital Stay

Provider Types Affected: Inpatient Hospitals, Ambulance Providers

Problem Description: The Medicare Severity Diagnosis Related Groups (MS-DRG) payment for inpatient services covers all items and non-physician services furnished to inpatients, including ambulance transports that Medicare beneficiaries receive during their inpatient stay.

- Ambulance providers and suppliers that render Medicare Part B transport services during an inpatient stay are required to bill the Inpatient Prospective Payment System (IPPS) hospital for those ambulance services. Ambulance suppliers should not bill Medicare separately under Part B.
- Ambulance transport provided by hospital-based ambulance providers and suppliers to beneficiaries, who are in an inpatient stay, are the responsibility of the inpatient hospital provider, with the exception of transports on the day of admission, day of discharge and during a leave of absence from the inpatient facility noted on the claim with occurrence span code 74 (defined as non-covered level of care) for the dates indicated plus one day.

Auditor Finding: The auditor found 1,067 ambulance claims submitted incorrectly. This resulted in recovered overpayments.

Guidance on How Providers Can Avoid These Problems:

Hospitals and ambulance providers are reminded of Medicare's policies and reimbursement rules for transport of hospital inpatients.

- Ambulance providers and suppliers may bill directly for services provided to a beneficiary for transport to a hospital on the day of admission, the day of discharge and during a leave of absence from the inpatient facility noted on the claim with occurrence span code 74 for the dates indicated plus one day.
- Ambulance providers and suppliers that render Medicare Part B transport services during an inpatient stay are required to bill the hospital, instead of billing Medicare, for that ambulance service.
- Hospitals must furnish ambulance services to inpatients directly or by arrangement with ambulance providers.

Under Medicare's Inpatient Prospective Payment System (IPPS), Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS), Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) and other inpatient payment systems, Medicare Administrative Contractors (MACs) reimburse hospitals a predetermined amount

for services furnished to Medicare beneficiaries based on their illness and their classification under the respective payment systems (MS-DRG, IRF PPS, etc.).

The payment for inpatient services covers all items and non-physician services furnished to inpatients including ambulance transports that Medicare beneficiaries receive during their inpatient stay. This excludes transports on the day of admission, the day of discharge and any dates of service listed with occurrence code 74 plus one day. These transports may include transportation of an inpatient by ambulance to and from another facility to receive specialized services not available at the hospital where the beneficiary is an inpatient.

Accordingly, ambulance providers and suppliers that render Medicare Part B transport services during an inpatient stay are required to bill the hospital, not Medicare, for these services. All items and non-physician services (including ambulance services) furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to PPS, and to both ground and air ambulance services.

Resources:

- MLN Matters® Article MM3933, “Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay,” explains this issue. The article is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM3933.pdf> on the CMS website.
- The “Medicare Benefit Policy Manual”, Chapter 10, “Ambulance Services,” Section 10, “Ambulance Service” and 10.3.3, “Separately Payable Ambulance Transport Under Part B Versus Patient Transportation That is Covered Under A Packaged Hospital Service” are available at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS website.
- The “Medicare Claims Processing Manual”, Chapter 3, “Inpatient Hospital Billing,” Sections 10.4, “Payment of Non-Physician Services for Inpatients,” and 10.5, “Hospital Inpatient Bundling” is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf> on the CMS website.
- The “Medicare Claims Processing Manual”, Chapter 15, “Ambulance,” Sections 10.2, “Summary of the Benefit” and 30.A, “Modifier Specific to Ambulance Services,” are available at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS website.



Did you know...

A Medicare overpayment is a payment made to a physician or supplier that exceeds amounts due and payable under Medicare statute and regulations. Once the overpayment is determined, the amount becomes a debt owed by the debtor to the Federal government. Federal law requires CMS to seek the recovery of all identified overpayments. For more information, please refer to the Medicare Learning Network® (MLN) fact sheet “[The Medicare Overpayment Collection Process](#).”

Recovery Audit Finding: Billing for Arformoterol (Brovana) (J7605) and Formoterol fumarate (Perforomist) (Q4099)

Provider Types Affected: Durable Medical Equipment (DME) Suppliers

Problem Description: Improper payments exist due to excessive units being billed per patient per month for the following drugs:

- **Arformoterol (Brovana) (HCPCS J7605)** – A unit dose of Arformoterol (Brovana) (Healthcare Common Procedure Coding System (HCPCS) code J7605) contains 15 micrograms, which is the maximum allowed amount per dose supplied in one vial.

- ✓ One unit of service is equal to one vial of Brovana, the equivalent of 15 micrograms of Brovana. Patients are allowed a maximum of two vials of arformoterol (a total of 30 micrograms) per day, which corresponds to the maximum therapeutic benefit of Arformoterol.

- ✓ There is no therapeutic benefit to using Brovana at doses higher than listed here, according to evidence-based literature.
- ✓ Therefore, units billed should not exceed two units (equal to two vials) per day per patient.

- **Formoterol fumarate (Perforomist) (HCPCS Q4099)** Formoterol fumarate (Perforomist) (HCPCS Q4099) is allowed twice per day.

- ✓ One vial contains 20 micrograms for a total of 40 micrograms per day; therefore, units billed should not exceed two units (equal to two vials) per day per patient.

Below are examples of erroneous billing for these drugs.

Arformoterol (Brovana) (HCPCS J7605)

Example 1:

A 75-year-old patient with chronic obstructive pulmonary disease (COPD) used a home nebulizer with Brovana. The patient was ordered Brovana twice a day. The patient was given a one month's supply. The DME supplier billed for 930 units, equivalent to 13,500 micrograms.

Finding:

The supplier should have billed for 62 units. This error occurs when the supplier multiplies the 31 days' supply by the dosage of 30 micrograms (31 days times 30 micrograms = 930 units), instead of by 2 units (31 days times 2 units = 62 units).

Example 2:

A 68-year-old patient with COPD was using Brovana via a home nebulizer. The DME supplier billed for 2700 units, a 90-day supply.

Finding:

The supplier should have billed for 180 units (2 vials per day times 90 days = 180 units). This error occurs when the DME supplier multiplies the number of micrograms dispensed by the 90-day supply. (90 days times 30 micrograms = 2700 units).

Formoterol fumarate (Perforomist) (HCPCS Q4099)

Example 3:

The DME supplier billed for 1240 units of Perforomist, with a 30-day dispensing fee (HCPCS Q0513). This number of units correlates to exactly the number of micrograms in one month's supply of twice daily doses. (1240 units divided by 20 micrograms = 60 units).

Finding:

The supplier billed inappropriately, using micrograms instead of units. The proper billing should have been 62 units.



Example 4:

The DME supplier billed for 3600 units of Perforomist, with a 90-day dispensing fee (HCPCS Q0514). This number correlates to the exact number of micrograms for a 90-day supply.

Finding:

The supplier billed inappropriately, using micrograms instead of units (1 unit = 20 micrograms). The proper billing should have been 180 units.

Resulting Actions:

The auditors are recovering overpayments for over 19,600 claims due to these billing errors.

Guidance on How Providers Can Avoid These Problems:

- ✓ DME suppliers should review the instructions on the proper billing for **Arformoterol (Brovana)**. The amount billed per month or per 90 days should be in units, not in micrograms. The most common DME charges should be 62 units per month or 180 units for a 90-day supply.
- ✓ DME suppliers should review the instructions for proper billing for **Formoterol fumarate (Perforomist)**. The amount billed per month or per 90 days should be in units, not in micrograms. The most common DME charges should be 62 units for a month's supply or 180 units for a 90-day supply.

Resources:

- The Local Coverage Determination (LCD) for Nebulizers (L11499) provides detailed information about billing for nebulizer drugs and supplies and is available at <http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11499> on the CMS website.
- The "Medicare National Coverage Determinations Manual", Chapter 1, Part 4, Sections 200.2 and 280.1 provides additional information about coverage determinations for drugs and medical supplies and is available at http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf on the CMS website.
- Please contact your regional DME MAC about questions related to billing for nebulizer drugs. A directory of toll-free numbers is available at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.



Please ensure that your inpatient rehabilitation admission is reasonable and necessary. Verify and document that the patient requires, can tolerate, and significantly benefit from an intensive rehabilitation therapy program delivered in a hospital inpatient setting. Please refer to the [Medicare Benefit Policy Manual, Chapter 1, Section 110](#), for more information.

Recovery Audit Finding: Diseases and Disorders of the Circulatory System

Provider Types Affected: Inpatient hospitals

Problem Description: Medicare pays for inpatient hospital services that are medically necessary for the setting that is billed. Claims with MS-DRG 312 Syncope & Collapse and MS-DRG 313 Chest Pain were reviewed for medical necessity. Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the patient's diagnosis and condition at any time during their stay. The patient must demonstrate signs and symptoms severe enough to warrant the need for medical care. He or she must also receive services of such intensity that they can only be furnished safely and effectively on an inpatient basis.

Example:

The patient is a 71 year old female who presented to the emergency department with chest discomfort and fatigue. The patient had a history of hypertension and aortic ascending aneurysm repair. The patient's blood pressure was 120/70, pulse 80, respirations 16, temperature 98.6, and an oxygen saturation of 98% on room air. The patient did not experience any headache, nausea, or shortness of breath. The patient's lungs were noted to be clear and she had a regular heart rate and rhythm. Laboratory findings and cardiac enzyme levels remained within normal limits. A chest x-ray revealed no active disease. An electrocardiogram showed sinus rhythm. A stress test revealed no ischemia. A computed tomography of the chest revealed dilation of

the aorta arch and bilateral thyroid nodules. The patient was treated with follow up testing, monitoring and supplemental oxygen. The patient's symptoms resolved with treatment and the patient did not experience any further chest discomfort.

Auditor Finding:

In summary, the severity and complexity of the patient's condition upon presentation did not warrant an inpatient stay by Medicare's criteria. The patient was admitted for chest discomfort and fatigue. The plan of care was to rule out an acute coronary event and treat the patient's symptoms. The patient's symptoms improved and no complications were experienced.

The evaluation and planned treatment could have been rendered in an outpatient status. The admitting provider could have reasonably anticipated that the patient's problems would resolve within 24 hours or that a decision to admit to

inpatient status could have been made safely within 24 hours. In conclusion, the recovery audit found that Medicare's requirements for inpatient status have not been met.

Guidance on How Providers Can Avoid These Problems:

Providers should educate themselves about the medical necessity of inpatient admission.

- The "Medicare Benefit Policy Manual" states that the physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark; that is, they should order admission for patients who are expected to require hospital care for 24 hours or more, and treat other patients on an outpatient basis.

However, the decision to admit a patient is a complex medical judgment that can only be made after the physician has considered a number of factors. These factors include the patient's medical history and current medical needs, types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to consider when deciding to admit a patient include:

- ✓ severity of the signs and symptoms exhibited by the patient;



- ✓ medical predictability of something adverse happening to the patient;
- ✓ need for diagnostic studies that are appropriate for outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to help assess whether the patient should be admitted; and,
- ✓ availability of diagnostic procedures at the time and location where the patient presents.

- The “Medicare Benefit Policy Manual,” Chapter 1, Section 10, “Covered Inpatient Hospital Services Covered Under Part A,” is available at <http://www.cms.gov/manuals/Downloads/bp102c01.pdf> on the CMS website.

- The Medicare Learning Network® (MLN) publication, “Medicare Physician Guide,” is designed to provide education on the Medicare Program and includes a section on Part A inpatient hospitals. This publication is available at: <http://www.cms.gov/MLNProducts/downloads/MedicarePhysicianGuide/ICN005933.pdf> on the CMS website.

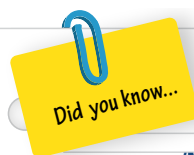
- The Local Coverage Determination (LCD) for Acute Care: Inpatient, Observation and Treatment Room Services (L27548) discusses hospital inpatient services and is available at <http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=27548> on the CMS website.

- The “Medicare Claims Processing Manual” states that observation care is a well-defined set of specific, clinically appropriate services. These services include ongoing short term treatment, assessment, and reassessment that are furnished while a decision is made about whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

- ✓ Observation services are commonly ordered for patients who present to the emergency department and then require a significant period of treatment or monitoring to make a decision about their admission or discharge. Observation services are covered only when provided by a physician’s order or another individual authorized by State licensure law and hospital staff by-laws to admit patients to the hospital or to order outpatient services.

- ✓ Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In most cases, the decision to discharge a patient from the hospital after resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

The “Medicare Claims Processing Manual”, Chapter 4, Sections 290.1, Outpatient Observation Overview, and 290.2.2 General Billing Requirements for Observation Services, is available at <http://www.cms.gov/manuals/downloads/clm104c04.pdf> on the CMS website.



Visit the Medicare Learning Network® (MLN) Provider Compliance web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp for the latest educational products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities.

Recovery Audit Finding: Lower Limb Suction Valve Prosthesis

Provider Types Affected: Durable Medical Equipment (DME) Prosthetic Suppliers

Problem Description: Region A DME Medicare Administrative Contractor (MAC) Local Coverage Article A25310 (Lower Limb Prostheses), which is associated with Local Coverage Determination (LCD) L11464 (Lower Limb Prosthesis), states that:

- Healthcare Common Procedure Coding System (HCPCS) code L5647 (Addition to lower extremity, below knee suction socket), and HCPCS L5652 (Addition to lower extremity, suction suspension, above knee or knee disarticulation socket), describe a modification to a prosthetic socket that incorporates a suction valve in the design.

The items described by these codes are not components of HCPCS L5671 (Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard, or equal), excludes socket insert).

In addition, Region A DMERC PSC Bulletin Bul20030901 "Use of HCPCS Code L5647 and L5652-Clarification" further explains that it is inappropriate to bill L5647 or L5652 with code L5671. Code L5671 was created specifically to address suspension sockets using mechanical locking mechanisms, and not as an "add on" for suction suspension. This bulletin is available at http://www.medicarenhic.com/dme/medical-review/mr_bulletins/mr_bulletin_archive/socketinserts.pdf on the Internet.

Examples of Coding Errors:

Below are two examples of errors in coding/billing for lower limb suction valve prostheses:

Example 1:

A prosthetic supplier for a beneficiary bills L5647-K3-RT on the same date of service (5/26/10) as L5671-K3-RT.

Finding:

According to the references, it is inappropriate to bill L5647 with L5671. Therefore, L5647 is identified as an overpayment.

Example 2:

A prosthetic supplier for a beneficiary bills L5652-RT on the same date of service (6/1/10) as L5671-RT.

Finding:

According to the references, it is inappropriate to bill L5652 with L5671; therefore, L5652 is identified as an overpayment.

Guidance on How Providers Can Avoid These Problems:

Providers and their billing coders should always refer to the relevant LCD to ensure that claims are correctly coded prior to submitting them to the MAC. Consider the following actions:

- Review current LCDs by searching the Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website. Enter the HCPCS

code or "lower limb prosthesis" in the appropriate fields and select the region you work in. All of the current and relevant articles will be displayed.

For example, a search for "lower limb prostheses," "code L5671," or the article "A25310," as noted above, would show the current Policy Article for Lower Limb Prostheses contains information about the appropriate coding:

- ✓ Code L5671 includes both the part of the suspension locking mechanism that is integrated into the prosthesis socket and the pin(s), lanyard, or other component which is attached to the socket insert. L5671 does not include the socket insert itself. The socket inserts used in conjunction with a suspension locking mechanism are billed with codes L5673, L5679, L5681, or L5683, as appropriate. These codes include socket inserts with or without a distal umbrella adapter for attaching the pin or lanyard of the locking mechanism.

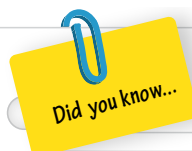


✓ Note that code L5671 was created specifically to address suspension sockets using mechanical locking mechanisms, not as an “add on” for suction suspension.

✓ Codes L5647 and L5652 describe a modification to a prosthetic socket that incorporates a suction valve in the design. The items described by these codes are not components of a suspension locking mechanism (L5671). A suction valve (L5647, L5652) is rarely needed when a suspension locking mechanism is being used. If both are provided, there should be documentation in the supplier’s records that describes the medical necessity of each for the specific patient.

✓ Note that code L5647 describes a type of suspension system and is intended for use with sockets that incorporate a suction valve in their design. The parallel code for above knee prostheses is code L5652 (addition to lower extremity, suction suspension, above knee or knee disarticulation socket). The reimbursement for codes L5647 and L5652, takes into account the time and labor to incorporate this suction valve into the socket suspension system.

- Please contact your regional DME MAC about questions related to coding for prosthetics. A directory of toll-free numbers is available at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.
- Prosthetic providers should become familiar with the “Medicare Benefit Policy Manual”, Chapter 15, Sections 120, Prosthetic Devices and 130, Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes, available at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf> on the CMS website.



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Recovery Audit Finding: Minor Surgery and Other Treatment Billed as Inpatient Stay

Provider Types Affected: Inpatient Hospital

Problem Description: Based on CMS regulations, First Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) Reports, Recovery Audit Demonstration experience, recovery auditors identified payment for inpatient care when only outpatient care (minor surgical or other treatments) was provided.

The following two scenarios provide examples of billing for inpatient care when only outpatient care was provided.

Example 1:

An 81-year-old male patient, with chronic sinusitis and a history of two recent sinuplasties, underwent Peripherally-Inserted Central Catheter (PICC) placement on June 8, 2009, for a course of Intravenous (IV) antibiotic therapy. The procedure was reported to have been completed without complications and placement was confirmed by chest X-ray.

In addition, the course of antibiotics was reported to be well tolerated and both physician and nursing notes reported the patient to be stable, including vital signs, physical examination, and laboratory tests.

Although the medical record did not contain an admission order, the claim indicated inpatient dates of service from June 8, 2009, to June 9, 2009, for ICD-9-CM Code 473.8 (Other chronic sinusitis).

Auditor Finding:

The auditor found that the medical necessity for the inpatient admission was not supported. The claim was identified as an overpayment.

Action:

The auditor corrected payment of the claim.

Example 2:

A 74-year-old female was evaluated on January 26, 2009, for a corneal transplant. The procedure was scheduled for February 9, 2009 with a planned 23-hour observation post-operative care based on the need to remain in supine position.

The medical record contained physician orders for admission to outpatient surgery followed by a 23-hour observation. It was documented that the procedure was accomplished without complications and that the post-operative course was uneventful.

Although the medical record did not contain an admission order, the claim indicated Dates of Service (DOS) for inpatient stay from February 9, 2009, to February 10, 2009, for ICD-9-CM code 371.57 (Endothelial corneal dystrophy).

Auditor Finding:

The auditor found that the medical necessity for the inpatient admission was not supported. The claim was identified as an overpayment.

Action:

The auditor corrected the payment of the claim.

Guidance on How Providers Can Avoid These Problems:

When performing minor surgery or other treatments in the hospital:

✓ Patients who are admitted into a hospital for a specific minor surgical procedure, or other treatment, that is expected to keep them in the hospital for less than 24 hours, are (for coverage purposes) considered **outpatients** regardless:

- Of the hour they came to the hospital;
- Whether they used a bed; and
- Whether they remained in the hospital past midnight.



✓ If such a patient is subsequently admitted to the hospital, their medical record must indicate that:

- Inpatient hospital care was medically necessary, reasonable, and appropriate for their diagnosis and condition at any time during the stay;
- The patient demonstrated signs and/or symptoms severe enough to warrant the need for medical care; and
- The patient must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

✓ In general, a 24-hour period should be used as a benchmark for admission (patients who are expected to require hospital care for 24 hours or more should be admitted. Other patients should be treated on an outpatient basis).

✓ The physician (or other practitioner) responsible for the patient's care at the hospital is also responsible for deciding whether they should be admitted as an inpatient.

✓ The decision to admit a patient involves the consideration of a number of factors, which include such things as:

- The severity of the signs and symptoms the patient exhibits;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not

ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and

- The availability of diagnostic procedures at the time when and at the location where the patient presents.

✓ The "Medicare Benefit Policy Manual," Chapter 1, "Inpatient Hospital Services Covered Under Part A," Section 10, "Covered Inpatient Hospital Services Covered Under Part A" provides information about Medicare payment for inpatient services and performance of hospital-based minor surgeries, or other treatments. This manual is available at <http://www.cms.gov/manuals/Downloads/bp102c01.pdf> on the CMS website.

✓ The "Medicare Program Integrity Manual," Chapter 6, "Intermediary MR Guidelines for Specific Services," Section 6.5.2, "Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims" provides information for determining medical necessity and the appropriateness of an inpatient admission. You can find this manual at <http://www.cms.gov/manuals/downloads/pim83c06.pdf> on the CMS website.

✓ The following MLN Matters® articles provide education about Recovery Audit demonstration-identified vulnerabilities:

- MLN Matters® Special Edition Article SE1024, "Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient

Documentation Submitted," is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf> on the CMS website.

– MLN Matters® Special Edition Article SE1027, "Recovery Audit Contractor (RAC) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals," is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1027.pdf> on the CMS website.

– MLN Matters® Special Edition Article SE1028, "Recovery Audit Contractor (RAC) Demonstration High-Risk Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals," is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1028.pdf> on the CMS website.

– MLN Matters® Special Edition Article SE1037, "Guidance on Hospital Inpatient Admission Decisions," provides a review of CMS policy guidance related to inpatient admissions. This article is available at <http://www.cms.gov/MLNMattersArticles/Downloads/SE1037.pdf> on the CMS website.

Recovery Audit Finding: Respiratory System Diagnosis Related Group (DRG) 076, Medicare Severity Diagnosis Related Groups (MS-DRGs) 166,167, 177, 178, and 179

Provider Types Affected: Inpatient hospitals

Problem Description: Recovery auditors validated the following DRGs to determine whether the principal diagnosis and all secondary diagnoses identified as a CC or MCC were actually present, correctly sequenced and coded; and that the procedure codes were correctly assigned based on chart documentation:

- DRG 076 (MS-DRG 166 – Other respiratory system OR procedures with Major Complications or Comorbidities (MCC);
- DRG 167 – Other respiratory system OR procedures with Complications or Comorbidities (CC), 177 – Respiratory Infections & Inflammations w/MCC, 178 – Respiratory Infections & Inflammations w/ CC; and/or
- DRG 179 – Respiratory infections & inflammations w/o CC/MCC).

Specifically, auditors reviewed Procedure Code 33.27 -- Closed Endoscopic Lung Biopsy.

The following two examples demonstrate the inappropriate use of Procedure Code 33.27.

Example 1:

The patient underwent a biopsy of the left upper lobe bronchus.

Auditor Finding:

There is no indication that the physician punctured the terminal bronchus to obtain lung tissue.

Action:

The auditor changed the ICD-9-CM Procedure Code from 33.27 (Closed endoscopic lung biopsy) to code 33.24 (Closed (endoscopic) biopsy of bronchus) to reflect that an endoscopic biopsy of the right upper lobe bronchus was actually performed. This yielded an overpayment.

Example 2:

The patient's radiology report noted that the left bronchus and proximal portions of the lingular and lower lobe bronchi were narrowed by a mass. The procedure report stated: "He had a necrotic lesion in the left lower lobe that was biopsied." The endoscopic procedure/conscious sedation report recorded that biopsy forceps were used for the procedure.

Auditor Finding:

The procedure report did not indicate that a transbronchial biopsy was performed. There was no indication that the physician punctured the terminal bronchus to obtain lung tissue under fluoroscopic guidance.

Action:

The auditor changed the ICD-9-CM Procedure Code from 33.27 (Closed Endoscopic Lung Biopsy) to code 33.24 (Closed (endoscopic) biopsy of bronchus) to reflect that an endoscopic biopsy of the right upper lobe bronchus was actually performed. This yielded an overpayment.

Guidance on How Providers Can Avoid These Problems:

Fluoroscopic guidance in obtaining lung tissue is essential for the bronchoscopist to identify the tissue needed for biopsy. While there may be medical record documentation of a transbronchial biopsy, when coding for lung biopsy:

- ✓ Review the "Medicare Program Integrity Manual," Chapter 6, "Intermediary MR Guidelines for Specific Services," Section 6.5.3, "DRG Validation Review," for details on the processes and procedures Medicare contractors and auditors use to determine the correctness and appropriateness of medical record coding. This includes the validation of the principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG. This manual is available at <http://www.cms.gov/manuals/downloads/pim83c06.pdf> on the CMS website.
- ✓ Review the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) report, "DRG 79 Validation Study Update: Respiratory Infections and Inflammations," which was released in February 1993. The report is available at <http://oig.hhs.gov/oei/reports/oei-12-89-00193.pdf> on the OIG website.

✓The following MLN Matters® articles provide education about Recovery Audit demonstration-identified vulnerabilities:

- MLN Matters® Special Edition Article SE1024, "Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted," is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf> on the CMS website.
- MLN Matters® Special Edition Article SE1027, "Recovery Audit Contractor (RAC) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals," is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1027.pdf> on the CMS website.

- MLN Matters® Special Edition Article SE1028, "Recovery Audit Contractor (RAC) Demonstration High-Risk Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals," is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1028.pdf> on the CMS website.
- MLN Matters® Special Edition Article SE1037, "Guidance on Hospital Inpatient Admission Decisions," provides a review of CMS policy guidance related to inpatient admissions. This article is available at <http://www.cms.gov/MLNMattersArticles/Downloads/SE1037.pdf> on the CMS website.



Recovery Audit Finding: Chronic Obstructive Pulmonary Disease (COPD) Medicare Severity Diagnosis Related Group (MS-DRGs) 190, 191, and 192 (Medical Necessity Review and MS-DRG Validation)—Inappropriate and Insufficient Documentation

Provider Types Affected: Inpatient Setting

Problem Description: Providers have been incorrectly coding/sequencing COPD exacerbation and respiratory distress as the principal diagnosis, instead of correctly coding the condition found to be responsible for occasioning the admission to the hospital after study as the principal diagnosis. Presentation of COPD exacerbation or respiratory distress on presentation to the ED is not a sufficient reason to code COPD as the primary diagnosis. When the provider has incorrectly coded COPD or respiratory distress as the principle diagnosis, but the remaining medical documentation indicates that after study another diagnosis was responsible for the admission, frequently an overpayment has been made to the provider.

Recovery Auditors performed coding validation on (MS-DRG) 190 (Chronic obstructive pulmonary disease w MCC), 191 (Chronic obstructive pulmonary disease w CC), and 192 (Chronic obstructive pulmonary disease w/o CC/MCC). The purpose of MS-DRG Validation is to determine that the principal diagnosis and all secondary diagnoses identified as a Complication or Comorbidity (CCs) and Major Complication or Comorbidity (MCCs) are actually present, correctly sequenced, and coded. Reviewers will validate for MS-DRG 190 and or 191, principal diagnosis, secondary diagnosis and procedures affecting, or potentially affecting the DRG.

Guidance on How Providers Can Avoid These Problems:

- ✓ Providers should know that Recovery Auditors will perform MS-DRG validation on Prospective Payment System (PPS) claims, as appropriate, and review the medical record for medical necessity and DRG validation. The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the patient, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the patient's medical record.

Be aware that reviewers will validate:

1. Principal diagnosis;
2. Secondary diagnoses; and
3. Procedures affecting or potentially affecting the DRG.

The following items are also important:

1. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis.
2. The other diagnoses identified should represent all conditions present during the admission that impact the stay.
3. The Present on Admission (POA) indicator should be reported for all diagnoses and must be coded correctly.

NOTE: When coding for an inpatient hospital stay, the diagnostic and procedural information and the beneficiary's discharge status (as the hospital coded and reported on its claim) must match both the attending physician description and the information contained in the beneficiary's medical record.

Resources:

- Review the "ICD-9-CM Official Guidelines for Coding and Reporting" at http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm to ensure complete and accurate coding.
- The "Medicare Program Integrity Manual," Chapter 6, "Intermediary MR Guidelines for Specific Services" (pages 37-38, Sections A and C of Ch 6.5.3), which is available at <http://www.cms.gov/manuals/Downloads/pim83c06.pdf> on the CMS website.
- Change Request (CR) 5679, "Present on Admission Indicator Systems Implementation," is available at <http://www.cms.gov/transmittals/downloads/R289OTN.pdf> on the CMS website.
- Review the item titled "Recovery Audit Finding: Excisional Debridement – Incorrect Coding," on page 5 of the February 2011 issue of the "Medicare Quarterly Compliance Newsletter," which is available at http://www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN905712.pdf on the CMS website.

Recovery Audit Finding: Overutilization of Positive Airway Pressure (PAP) and Respiratory Assist Device (RAD) Accessories—Improperly Billed Quantities

Provider Types Affected: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers

Problem Description: Recovery Auditors found that suppliers are billing for PAP and RAD accessories in quantities that exceed the determined medically-necessary amounts. There is a common table for PAP and RAD Local Coverage Determinations (LCDs) that represents the usual maximum amount of accessories expected to be medically necessary. Quantities of supplies greater than those described in the policy as the usual maximum amounts will be denied as not medically necessary. Below are two examples of services that were improperly billed:

Example 1:

A beneficiary receives an A7034 (nasal interface (mask or cannula type) used with a PAP device, with or without head strap). The Date of Service is July 21, 2010. On Date of Service September 30, 2010, the beneficiary received another A7034. The PAP/RAD LCDs state the beneficiary is allowed **one A7034 every three months**.

Auditor Finding:

The A7034 received on September 30, 2010, is unallowable; therefore, payment for the A7035 is deemed an overpayment.

Example 2:

The beneficiary received an A7035 (headgear used with PAP device) on August 5, 2010. On November 24, 2010, the beneficiary received another A7035. The PAP/RAD LCDs state the beneficiary is allowed **one A7035 every six months**.

Finding:

The A7035 given to the beneficiary on 11/24/2010 is unallowable and therefore payment for the A7035 is deemed an overpayment.

Guidance on How Providers Can Avoid These Problems:

The key to correctly billing for PAP and RAD accessories is to be aware of the allowable quantity.

A supplier must not dispense more than a certain quantity of PAP/RAD accessories at a time. Quantities of supplies greater than those described in the policy as the usual maximum amounts will be denied as not reasonable and necessary.

The relevant LCD is a Noridian LCD: L171 PAP Devices RAD and is available at https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/positive_airway_pressure_pap_devices_for_the_treatment_of_obstructive_sleep_apnea.htm on the Noridian website. This LCD contains an accessories table that represents the usual maximum amount of accessories expected to be reasonable and necessary. Below is the table that is posted on the Noridian website. For a complete description, visit the Noridian website.

ACCESSORIES:

Accessories used with a PAP device are covered when the Medicare coverage criteria for the device are met. If the Medicare coverage criteria are not met, the accessories will be denied as not reasonable and necessary.

The following table represents the usual maximum amount of accessories expected to be reasonable and necessary:

HCPSC Code	Amount
A4604	1 per 3 months
A7027	1 per 3 months
A7028	2 per 1 month
A7029	2 per 1 month
A7030	1 per 3 months
A7031	1 per 1 month
A7032	2 per 1 month
A7033	2 per 1 month
A7034	1 per 3 months
A7035	1 per 6 months
A7036	1 per 6 months
A7037	1 per 3 months
A7038	2 per 1 month
A7039	1 per 6 months
A7046	1 per 6 months

Suppliers could avoid overpayment by developing or enhancing edits to identify DME claims when there is overutilization of PAP/RAD accessories. Some audits are most efficiently handled through post-pay review. Correcting improper payments through post-payment review corrects the claim(s) identified and demonstrates an accurate billing practice.

Resources:

- The "Medicare National Coverage Determinations Manual," Chapter 1, "Coverage Determinations," Section 240.4, "Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep Apnea (OSA)," is available at http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf on the CMS website.
- MLN Matters® Article MM6048, "Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA)," is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM6048.pdf> on the CMS website.
- The Local Coverage Determination (LCD) for Respiratory Assist Devices (L5023) information is available at <http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=5023> on the CMS website.



Did you know...

The latest version of the Medicare Learning Network® (MLN) Products Catalog is now available! The MLN Products Catalog is a free, interactive downloadable document that lists all available MLN products. To access the catalog, visit <http://www.cms.gov/MLNGenInfo> and select the "MLN Products Catalog" from the "Downloads" section.

